Exhibit A: Creating an Integrated, Data Driven, Primary Care Medical Home Network to Improve the Health of the Most Vulnerable Residents in the City of Seattle

Excellence, best practice and innovation in the CHC Partner's service delivery systems are showcased in these short profiles of the work these CHCs are engaged and committed to on behalf of Seattle residents.

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Providing high quality care with respect and dignity to our city's most vulnerable residents	Dental care is a core safety net service closely tied to the mission of Public Health. The City's CHC Partners' dental investment contributes to the success of the Ten Year Plan to End Homelessness in King County by • addressing a gap in health care services that greatly affects the lives of homeless individuals • reducing costly emergency room visits; and • helping transition people to healthy, productive lives Investment supports a network of 17 dental clinics that provided, in 2012, a total of 72,547 visits. Seventy nine percent (79%) of these visits were to non-white residents, 38% were uninsured visits, and 29% were to	**Public Health Seattle King County (PHSKC)** has used this investment to focus on care for the homeless with the majority of care provided at the Downtown Public Health Clinic on 4th and Blanchard which serves exclusively homeless adults and teens. In 2012, nearly half of the dental visits from homeless individuals funded by the City's investment were delivered at PHSKC's dental clinics. The dental clinics are providing high quality dental care and are tracking their success with multiple performance measures. These measures include productivity targets, quality standards for documentation and customer satisfaction surveys. The Downtown clinic, in 2012, was at 101% of capacity and treated 2480 homeless patients. Chart audits show that documentation has dramatically improved over past years and is now more than 90% of all visits are being appropriately documented. Operating a clinic for the homeless requires an approach to patient care that meets their needs, as evidenced by customer satisfaction surveys that rank the clinic at 4.7 out of 5 stars and 99% of

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	homeless persons. Seventy-eight percent (78%) of the children and 50% of the adults seen completed their dental treatment plans. These treatment plan completion rates rank with high performing dental clinic rates nation-wide.	patients saying they would recommend the clinic to their friends. The demand for emergency services at the clinic is substantial. In 2012, 1377 emergency patients were seen. Having access to care prevents patients from showing up at hospital emergency rooms seeking pain relief, thereby relieving the burden on downtown's busy emergency departments. Providing dental care to this population greatly reduces pain and helps transition people to healthy, productive lives. In 2012 over seven hundred homeless clients were restored to oral health. Treatment completion rates are monitored and reported quarterly. Nearly half of the patients complete their dental treatment plans (which commonly are quite extensive) within a year.
Supporting cost effective care that benefits the City of Seattle's system of care	The clinic networks supported by this city investment play a key health care role in the city's most poverty-stricken neighborhoods. This investment increases significantly the capabilities of the CHC network, supporting multidisciplinary teams who are culturally sensitive and for whom treatment is a priority.	Sixty-eight percent (68%) of **Pioneer Square Clinic's** patients call downtown Seattle home, with the clinic serving their medical and mental health needs. Fifty-three percent (53%) of Pioneer Square's patients are homeless, and 74% are living at 200% of poverty level or below. Located in close proximity to several overnight shelters, Pioneer Square's Walk-In clinic opens for clients at 7:00 a.m. to coincide with early morning shelter check-outs. Seattle's most vulnerable patients are served here –

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		individuals who are not currently established in primary care, new to town, uninsured, undocumented or who lack the ability to keep traditional primary care appointments due to mental illness or substance abuse. In 2012, only 43% of the 8,118 walk-in visits were billable medical visits, with the remainder of the appointments addressing patient's care needs provided by nurses, social workers, and pharmacists.
Primary Care Medical Home – Integrating Oral Health	**Oral health** is linked to overall health and well-being with profound disparities in oral health status based on social economic status, race, and being a member of a vulnerable population. Ninety-three percent (93%) of 2012 and 2011 uninsured Seattle dental users reported incomes at or below 200% of the federal poverty level. The most vulnerable populations served are the city's children, elderly, special needs and homeless populations, representing 74% of the patients receiving dental services through this investment. Improved oral health reduces risks related to adverse pregnancy outcomes (PTL, LBW, preeclampsia), diabetes, obesity, oral cancer, and lower respiratory and heart diseases.	One of the unique hallmarks of Seattle's CHCs is the broad array of health care services they offer. As the demand for quality and affordable dental care has increased, so have the CHCs' innovations to provide care for the whole person. **Sea Mar** is shifting away from a solo oral health practice and is integrating medical-dental services with a special focus on reaching moms and young children (< 2 years) through their Perinatal Program. Moms determine the dietary and oral care habits of their children, and can also unknowingly transmit decay causing bacteria. By providing moms participatory guidance, patient education, then screening the moms and their children at the same visit, Sea Mar has been able to improve oral health and give children a healthier start. Using a quality improvement approach since 2010 that includes co-location, bi-directional referrals, staff training, and a focus on outcomes, Sea Mar is providing dental screening and referral services in multiple sites

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	Integration of medical and dental services allows CHC partners to restore to health, the whole person, not just fix a condition.	(WIC, family practice and dental clinics) and have increased services by 15% to children < 2 years (from 5% to 20%) and by 10% (from 40% to 50%) to pregnant women. Early childhood caries is the most common chronic disease of children with cavities. Hispanic children miss a lot of school due to dental health caries (American Academy of Pediatrics, http://www2.aap.org/ORALHEALTH/pact/ch4_sect6.cfm) and the consequential impacts of tooth loss, cavities, pain, infection, self-esteem and speech impairment. Sea Mar continues to focus on reaching these school age children with a 9% increase in volume from 2011 to 2012.
Promoting evidence-based and promising interventions	Community Health Centers are dedicated to evidence based practices with clinical teams in all networks routinely using nationally recognized evidence-based guidelines and population and community specific benchmarks to guide care delivery strategies. Part of these centers' success in improving health outcomes and access to services is their willingness to do innovative collaboration with health care experts, public health services, and other community health	Attention to health outcomes for **Neighborcare Health's** 3,000+ diabetic patients has long been a goal, but in the past three years the work has taken on greater intensity. The Board has identified improved diabetes care as one of its three top aims. During 2012 from the percentage of patients with an HbA1c of less than 7 (measure of glycemic control) went from 41.9% to 44.3%. Some of the strategies used to attain this improvement in glycemic control were: • Improvement of patient panel reports for individual providers and graphic displays of data.

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	centers to improve their health care delivery system. Fidelity is enhanced by an implementation framework that customizes interventions through thoughtful design, staff training, monitoring, and use of quality improvement methodology. Each organization is invested in ensuring that their staff understand their metrics for success, and cultivating and sustaining their engagement in quality improvement work in a variety of ways.	• Regular Diabetes Days at each clinic that bring together all members of the care team, including optometry, nutrition, and podiatric services for individual and group visits. • Regular care team meetings focused on problem solving for the most challenging patients. • Improved patient recall and development of "meaningful reminder calls" to patients • Encouraging progress on patient's self-management goals. • Deployment of clinic-specific improvement plans based on local needs and issues. • Use of standard care management guidelines across Neighborcare. In 2013, with the advice of Dr. David McCulloch from Group Health, Neighborcare broadened the goal to encompass a broader set of health outcomes for the diabetic population. Now using a "combo measure" the organization looks at the percentage of patients who have achieved all three of these outcomes: HbA1c less than 9, Blood pressure under 140 over 90, and lipids (blood cholesterol level) under 100. A group of senior leaders including the CEO, chief medical officer, manager of process improvement and QI advisor meet every two weeks to provide overall direction to the effort. The effective functioning of care teams is key and the leadership team continues to work on this effort.

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Achieving health equity and eliminating health disparities	Medically underserved patients face substantial financial, cultural and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services, also called wrap-around services, are non-clinical services such as interpretation, health education and case management that can increase access to health care and quality of care at CHCs. Enabling services utilization is associated with better diabetes outcomes and higher rates of child immunization. Studies suggest that enabling service beneficiaries are more likely to be minorities and with public or no insurance – a patient population profile that matches the clients served by this important investment.	Approximately 88% of **International Community Health Services'** (ICHS) patients have their diabetes controlled, a percentage 12% higher than the next highest performing CHC in this portfolio. ICHS's high rates for diabetes control ranks them in good company with the highest performing clinics in diabetes management in the country. ICHS has a unique patient population with a high percentage of elderly patients (17% vs. 5.4% average for state CHCs) and populations at higher risk for diabetes complications due to health disparities related to their race/ethnicity (*e.g.* the Japanese and Filipino communities among others). To this extent, ICHS takes additional actions to maintain or improve their patients' ability to control their diabetes. By targeting limited resources available for hypertension and diabetes management to patients with the greatest need for improvement, ICHS has and will continue to build upon a 30-month pilot population health management program that was completed in 2012. At the conclusion of the 30-month pilot, ICHS found that the data indicated a strong association between the pilot's interventions and an improvement in the health outcomes of the hypertensive and diabetic patients in the study group when compared to the control group of hypertensive and diabetic patients that did not receive the pilot's interventions. For example:

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		▪ Patients in the study group were 34.6% more likely to meet American Heart Association Guidelines of a blood pressure <140/90. ▪ The study group went from an average HbA1c of 10.4% down to 8.2% while the control group started with an average HbA1c of 10.6% and dropped to 9.2%. ICHS also found that the study group was two-times more likely to meet American Diabetes Association guidelines of an HbA1c < 7.0, and four times less likely for their diabetes symptoms to worsen than the control group in the population health management pilot. In order to achieve the improved health outcomes outlined above for the pilot's study group, ICHS dedicated additional staff time for the assessment and active management of the hypertensive and diabetic patients in the study group. ICHS staff ensured that the patients in this study group saw their primary care provider on at least a quarterly basis and linked them to a diverse menu of enabling and wraparound services; including pharmacy consultations for patients taking multiple medications, nutrition counseling, and individual and group health education (*e.g.* a six-session group diabetes class). Moving forward, ICHS has and will continue to build

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		upon and expand its population health management program, characterized by more intensive assessment and management of their hypertensive and diabetic patients. Their goal for 2013 is to reach 60% of their hypertensive and diabetic patients who have not been seen by their primary care provider within the previous three months. ICHS' investment in population health management has again underscored the importance of the sustainability of enabling and wraparound services, which are services that are underfunded and rarely reimbursed. Through its population health management program, ICHS is continually reminded of how integral these services are to improving the health of its patients, especially those with poorly managed chronic conditions. In 2012, in addition to providing 80,000 FQHC encounters (face-to-face encounters with medical, dental, and behavioral health providers), ICHS provided over 34,000 enabling and wraparound service encounters to its patient population, of which in 2012: ▪ 89% were non-white, ▪ 18% were 65 years or older, ▪ 29% were uninsured, ▪ over half were at or below 200% FPL, and ▪ 66% preferred to speak a language other than English.

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Promoting healthy development and health behaviors at every stage of life	In 2012, this investment served approximately 51,000 Seattle residents with approximately 163,000 medical visits. The health and wellness, and quality of life of mothers, infants and children is important and determines the health of the next generation and can influence future public health challenges. Many conditions during childhood, such as poverty, obesity or low birth weight, may impact a person throughout life. (Moore K. Children in poverty: Trends, Consequences and Policy Implications: Child Trends; 2009.). Recent efforts to address persistent disparities in infant health have employed a "life course" perspective to health promotion and disease prevention.	**Seattle Indian Health Board** served 71 perinatal care patients who delivered in 2012, with 83% seen in their first trimester of pregnancy. Team-based care ensures access to quality reproductive health and maternity services provided by a doctor, nurse and case manager. Early detection of high risk moms allows for referrals to specialists to support good health outcomes. Staff attend more than 180 community events a year providing parenting education. Twenty New Mom Luncheons are hosted each year to discuss health and parenting topics.
Building cross-sectional partnerships	Health-related community partnerships play a significant role in improving public health. Every CHC openly supports and recognizes the importance of working effective with other organizations by sharing best practices and lessons learned. Improved data collection methods and building shared	**Country Doctor's** commitment to comprehensive clinical diabetes care is evidenced in their support for their patients in managing their disease, using a multifaceted approach to support lifestyle changes that achieve healthy levels of blood sugar, cholesterol and blood pressure. Services include supporting medication or insulin management and health education that supports shared care planning for healthy eating,

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	understanding of the genesis of disease, risk factors and social determinants have strengthened these collaborations. The CHCs are active members in regional community health and primary care center associations, participate in learning collaboratives to transform care, and work to build capacity for adopting best practices and providing excellent quality care.	physical activity and regular blood glucose testing. Country Doctor strives to be at or above the Medicaid average on measures reported to HEDIS (effectiveness of care and utilization measures under the chronic condition management rubric for diabetes). For the past several years quarterly reports are run for each provider on their diabetic patients seen at least once in the prior year and include data points on a menu of measures including medical attention for nephropathy, BP, HbA1c and LDL screening and control measures. Access to eye exams has been severely limited by lack of insurance coverage, difficulty of patients navigating the larger medical system even when they do have insurance coverage and limited retinal eye exams provided by a volunteer MD four times a year. Applying the resources of this city investment, coupled with receipt of funding from a Community Health Network for Washington initiative to improve access to eye exams, Country Doctor is receiving a retinal camera to improve diabetic patient care and better focus their advocacy efforts for those who need referral for existent diabetic retinopathy. It is in this way that the organization continues to provide high quality comprehensive health care and have a positive impact on the health of the communities they serve.